Medwork Independent Review
5840 Arndt Rd., Ste #2
Eau Claire, Wisconsin 54701-9729
1-800-426-1551 | 715-552-0746
Fax: 715-552-0748
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ACCREDITED INDEPENDENT REVIEW ORGANIZATION

NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION
Workers' Compensation Health Care Non-network (WC)

DATE OF REVIEW: 7/12/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L4-L5 lumbar epidural steroid injection under fluoroscopy and IV sedation

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Texas State Licensed MD Board Certified Orthopedic Surgeon & Spine Surgeon

REVIEW OUTCOME [PROVIDE FOR EACH HEALTH CARE SERVICE IN DISPUTE]
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Upheld (Agree)
☒ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Texas Dept of Insurance Assignment to Medwork 6/26/2012,
2. Notice of assignment to URA 6/25/2012,
3. Confirmation of Receipt of a Request for a Review by an IRO 6/26/2012
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 6/25/2012
6. Letter from attorneys 6/25/2012, letter from insurance 6/20/2012, medical information 6/12/2012, letter from medical management solutions 6/8/2012, letter from anesthesia and pain management facility 6/4/2012, letter from insurance 5/30/2012, letter from anesthesia and pain management facility 5/15/2012, 4/24/2012, medical information 3/19/2012, letter from anesthesia and pain management facility 3/19/2012, medical information 3/12/2012, letter from imaging facility 3/12/2012.

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PATIENT CLINICAL HISTORY:

The patient is a female with a history of low back pain with "nonspecific bilateral lower extremity pain extending to the feet and decreased nonspecific left lower extremity sensation of unknown etiology." This was as per the xx/xx/xx, review/report. This electrodiagnostic report revealed lumbar radiculopathy "involving the L5 and S1 nerve roots bilaterally…"
The additional records submitted included the treating provider notes dated June 4, 2012. There was ongoing back, buttock, and leg pain. The letter, which is essentially a clarification appeal letter, revealed that the patient had been consistent with pain complaints. It was also noted that "she has all the clinical findings consistent with the Official Disability Guidelines to approve the procedure." It was noted that the patient continued on a combination of a potent narcotic, as well as a neuropathic pain medication. The documentation revealed a consideration for the aforementioned requested epidural steroid injection.

The denial letters describe the lack of evidence of "significant neural compression" at the L4-L5 or L5-S1 levels per MRI. The prior records from were also reviewed, documenting the decreased pinprick sensation in the L5-S1 distribution…," as noted on May 15, 2012, for example.

Additional records were also reviewed in detail, including the subjective and objective findings. The findings included that of decreased motor power at the L4 tibialis anterior and at the L5 extensor hallucis longus and S1 peroneal-associated muscles. There were also decreased reflexes at the knees and ankles bilaterally.

The record dated March 19, 2012, among others, revealed chronic back pain, lumbar disk protrusion at L4-L5 and L5-S1 and lumbar radiculopathy. The MRI findings from March 12, 2012, Imaging facility, revealed posterior central disk substance protrusion-herniation at L4-L5 and a central disk substance protrusion-herniation at L5-S1 in particular.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The clinical basis, findings, and conclusions used to support this decision are that this individual clearly has both subjective and objective findings of radiculopathy documented throughout this record. There is enough consistency within this record that evidences decreased sensation, motor power, and/or reflexes in combination. These clinical findings do, indeed, correlate with both the MRI findings and also the electrodiagnostic findings of radiculopathy at the same level or levels. The patient has objective findings consistent with clinical radiculopathy corroborated by adjunctive studies, and therefore the Official Disability Guidelines do, indeed, apply, and the patient has met all criteria for the requested L4-L5 lumbar epidural steroid injection under fluoroscopy with IV sedation. The request at this time is appropriate, reasonable, and medically necessary; therefore, the insurer's denial is overturned.

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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**